TIANA DICK, BM, MTA, MT-BC
Board Certified Music Therapist

CLIENT INFO:	
NAME:	PRONOUNS:
DATE OF BIRTH:	
PARENT/GUARDIAN (IF UNDER 18):	
ADDRESS:	
EMAIL:	PHONE:
DIAGNOSIS:	YEAR DIAGNOSED:

REFERRER INFORMATION:	
NAME OF REFERRER:	DATE:
PROFESSIONAL DESIGNATION OF REFERRER:	
RELATIONSHIP TO CLIENT:	
EMAIL:	PHONE:
REASON FOR REFERRAL:	
RELEVANT PHYSICAL, PSYCHOLOGICAL, BEHAVIOURAL, EMOTIONAL, EXPRESSIVE AND/OR SOCIAL NEEDS OF CLIENT:	

CONTACT INFO:
Phone: 250-327-9640
Website: www.islandaria.ca
Email: islandariamt@gmail.com

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RELEVANT MEDICATIONS:

ADDITIONAL INFORMATION:		
HAS THE CLIENT ENGAGED IN MUSIC THERAPY BEFORE?:	YES	NO
MUSIC THERAPIST NAME:		
HAS THE CLIENT ENGAGED IN ANY OTHER THERAPIES?:	YES	NO
THERAPIST NAME:		
DOES THE CLIENT INTERACT WELL ON A ONE-TO-ONE BASIS?	YES	NO
DOES THE CLIENT HAVE ANY SPECIAL SKILLS, HOBBIES OR INTERESTS?	YES	NO
EXPLAIN:		
DOES THE CLIENT PARTICIPATE APPROPRIATELY IN GROUP ACTIVITIES?	YES	NO
ADDITIONAL COMMENTS:		

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CONSENT:		
VERBAL CONSENT HAS BEEN GIVEN BY CLIENT OR GUARDIAN:	YES	NO
CLIENT/GUARDIAN IS HAPPY TO BE CONTACTED BY A MUSIC THERAPIST FROM ISLAND ARIA MUSIC THERAPY	YES	NO

REFERRER SIGNATURE:	DATE:
CLIENT/GUARDIAN SIGNATURE:	DATE:

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